Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

Employer Health Insurance Responsibility Disclosure 2007 Instructions

EMPLOYER INFORMATION

Employers must complete all relevant fields. For the reporting period ending September 30, 2007, Employer Health Insurance Responsibility Disclosure (Employer HIRD) forms are due to the Division of Health Care Finance and Policy (DHCFP) by December 15, 2007.

Completed, signed, and dated forms are accepted by conventional mail only. It is advised you retain a copy of your HIRD form for your own records. Please mail your hard-copy completed and signed Employer HIRD form to DHCFP:

Division of Health Care Finance and Policy
2 Boylston Street
Boston, MA 02116

ABBREVIATIONS

FEIN: Federal Employer Identification Number
D/B/A: Doing Business As, if applicable

DEFINITIONS

Employer: An Employing Unit subject to M.G.L. c. 151A, and the commonwealth, its instrumentalities, political subdivisions, an instrumentality of a political subdivision, including municipal hospitals, municipal electric companies, municipal water companies, regional school districts and any other instrumentalities as are financially independent and are created by statute.

Employee: An individual employed by any employer at a Massachusetts location, whether or not the individual is a Massachusetts resident, for at least one month.

Section 125 Cafeteria Plan: A cafeteria plan that meets the requirements of Title 26, Subtitle A, Chapter 1, Subchapter B, Part III, Section 125 of the Internal Revenue Code.

ANSWERS

1. **Employer Health Insurance Responsibility Disclosure (HIRD) filing determination***:*

Employers with 11 or more full-time equivalent (FTE) Massachusetts employees are required to file a completed and signed Employer HIRD. If the sum of total payroll hours for all employees during the determination period (October 1 through September 30) divided by 2,000 is equal to or greater than eleven, complete, sign and submit your Employer HIRD. If the number is less than 11, sign and submit the incomplete form. Please see DHCFP regulation 114.5 CMR 18.00 for further determination specifications.

2. **Section 125 Cafeteria Plan:**

Employers with 11 or more FTE employees are required under Commonwealth Connector Authority regulations to offer all employees participation in a Section 125

Cafeteria Plan. Please see regulation 956 CMR 4.00 for a more detailed explanation of the requirements and identification of those types of employees who are exempt from this requirement. If your business complied with this requirement as of July 1, 2007, please check the appropriate box.

3. **Premium Contribution:**
If your business paid a portion of the premium cost of a group health plan for any of your employees as of July 1, 2007, please check the appropriate box.

4. **Premium Contribution Percentage:**
If your business paid a percentage of the premium cost of a group health plan for any of your employees as of July 1, 2007, please report the percentage of the premium paid by your business for those employees by individual plan and/or family plan for full-time employees and/or by individual plan or family plan for part-time employees. In this case, a full-time employee is an employee who works the number of hours to meet employer and health insurer criteria to be considered full-time when contracting for employer-sponsored health insurance during the applicable base period. If your business did not offer to pay a portion of the plans for full-time employees or part-time employees, please enter "0" in the appropriate field.

5. **Total Monthly Premium (highest/lowest):**
If your business paid a portion of the premium cost of a group health plan for any of your employees as of July 1, 2007, please report the total monthly premium cost, including both the employer and employee portion of the monthly premium, of the least expensive and most expensive plans offered. Please report the monthly premium cost for an individual plan and a family plan. If your firm does not offer a family plan, please enter "0" in the appropriate field. If your business did not pay a portion of the premium cost of a group health plan for any of your employees as of July 1, 2007, please enter "0" in the appropriate fields.

6. **Open Enrollment Start Date:**
Please check the appropriate box to indicate the month of your business' next Group Health Insurance Plan open enrollment start date.

HELP

For questions concerning your Employer HIRD form, please call the Division of Health Care Finance and Policy's HelpDesk (800) 609-7232.